HIPAA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information

1. Authorization

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (healthcare provider) to use  and disclose the protected health information described below to

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (individual seeking the information).

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Effective Period

This authorization for release of information covers the period of healthcare  from:

a. □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_. OR

b. **□** all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records  relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of  alcohol or drug abuse).   OR

b. □ I authorize the release of my complete health record with the exception

 of the following information:    □ Mental health records

  □ Alcohol/drug abuse treatment    □ Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. This medical information may be used by the person I authorize to receive  this information for medical treatment or consultation, billing or claims payment, or  other purposes as I may direct.

5. This authorization shall be in force and effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date  or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing,  at any time. I understand that a revocation is not effective to the extent that any  person or entity has already acted in reliance on my authorization or if my  authorization was obtained as a condition of obtaining insurance coverage and the  insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for  benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this  authorization may be disclosed by the recipient and may no longer be protected by  federal or state law.



Signature of patient or personal representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of patient or personal representative and relationship to patient Date